Community Mental Health Affiliates' Options 2 Health: A Case Study

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Presentation to the

Region 1 Primary Care and Behavioral Health Integration Meeting

Nashua, New Hampshire

February, 2013

Community Mental Health Affiliates: Options 2 Health

An overview including a case study illustrating the process of the integration model for CMHA's behavior health primary care initiative.

Program Mission

To improve the quality of life for adult CMHA patients through appropriate medical care, wellness education and integration of medical and psychological treatment.

Model of Care

- **Provide direct embedded primary care within the CMHA mental health center**

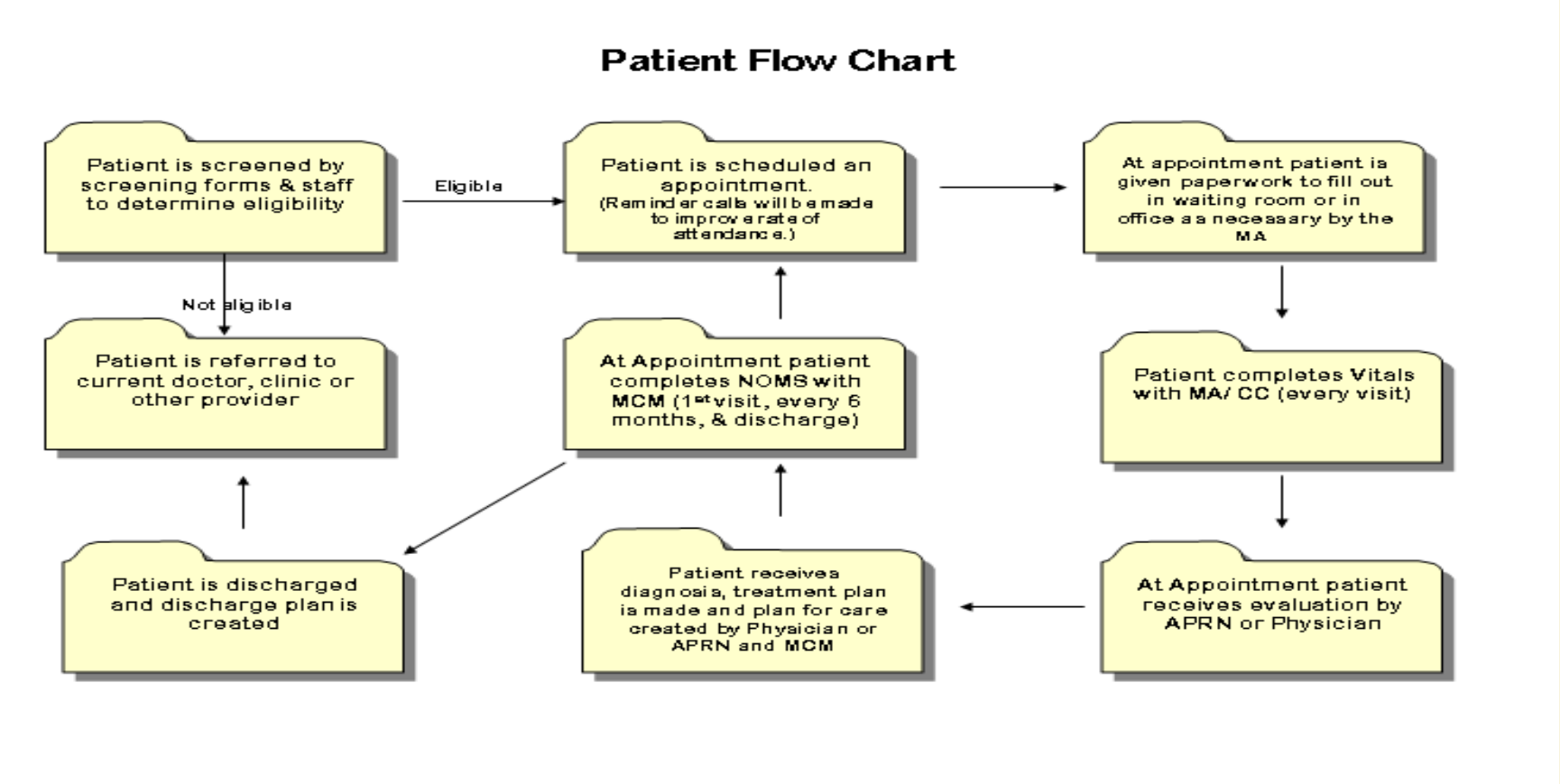
- **Collaboration between CMHA and The Hospital of Central Connecticut**

Tracks

1. Integrated Primary Care

2. Wellness

Integrated Primary Care



Wellness


Health Eating
Exercise
Smoking Cessation
Wellness Consultation
Wellness Events & Presentations

Case Study Client

*First seen by Options 2 Health on April 8, 2011.

*He was the first patient seen in the new O2H program.

*43 year old multi-racial male.

*At the first appointment, he presented for a medical history and physical examination.

Client Demographic Characteristics

Gender:	(•) Male ( ) Female
Race:	American Indian
Ethnicity:	Hispanic - Puerto Rican
Living Status:	Select Living Status
Marital Status:	Married
Smoking Status:	Current Smoker
Primary Language:	English
Other Language:	Spanish
Need Interpreter:	( ) Yes (•) No
Military Status:	Unknown

Client Diagnosis

Medical Diagnosis:

- Hypertension
- Obesity
- Diabetes Mellitus (Type II)
- Hyperlipidemia
- Chronic Headaches
- Chronic Back pains

Mental Health Diagnosis:

- Bipolar I Disorder
- Posttraumatic Stress Disorder
- Attention-Deficit/ Hyperactivity Disorder
- Predominantly Hyperactive-Impulsive Type I

Client Initial Engagement in PBHCI Service Model

- Client was initially screened using the O2H screening tool to establish eligibility for the program.
- O2H staff reviewed the screening information and contacted the patient to offer primary care.
- Patient was eager to centralize treatment to address conflict between mental health and medical health providers.

Planning: Individualized Integrated Care Plan

A. Primary Care Services:

- **Frequency - Every 3 months for maintenance and evaluation; as needed for sick visits.**
- **Provider(s) – THOCC physician & APRN**
- **Focus of service-**

1. **Obesity**
2. **Hypertension**
3. **Diabetes Mellitus Type 2**

Planning: Individualized Integrated Care Plan

B. Behavioral Health Services:

- **Frequency - Monthly med management visits, bi-weekly clinical visits, weekly psychosocial rehabilitation**
- **Provider(s) – CMHA psychiatrist, LMFT, PSR counselors**
- **Focus of treatment - Mood stabilization, improve social skills**

Planning: Individualized Integrated Care Plan

C. Wellness Activities/services

- **Frequency - Weekly**
- **Provider - Options 2 Health staff**
- **Types and focus of wellness-related services - Healthy Eating Groups & Exercise consultation**

Progress Monitoring

- Client's progress is monitored by psychiatric and medical teams using labs, BMI, and self-report of improvements.
- Patient is seen frequently for wellness checks and scheduled appointments.
- Information and progress is shared with team through consultation meetings and emails.

Client Indicators: TRAC Section H

Initial Weight/BMI	350/ 50.2
Follow-up Weight/BMI	323/47.2
Initial Blood Pressure	159/99
Follow-up Blood Pressure	138/87
Initial Total Cholesterol	165
Follow-up Total Chlolesterol	136

Client Indicators: TRAC Section H (cont'd)

Initial HDL	30
Follow-up HDL	24
Initial Triglycerides	307
Follow-up Triglycerides	393
Fasting Plasma Glucose	71

Client's total cholesterol and glucose levels are categorized 'not-at-risk'. Other indicators have improved, but client is still 'at-risk' in all other categories.

Client Outcomes

- Reduced weight
- Stopped smoking
- Impotency resolved
- Member of Advisory Committee
- Advocates with peers to encourage and support participation in O2H program